DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 9/30/12

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	Donelson Place Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves all right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	9/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patricia A. McHale	Administrator	9/6/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 79 received a letter of Notice of Medicare Non-Coverage on September 4, 2012. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Audit of residents in house who received Medicare benefits and changed to other payer sources since April 2012 will be conducted by the BOM by September 14, 2012; to verify that the Notice of Medicare Non-Coverage was provided. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** BOM and Social Services Director received 1:1 inservice by the Administrator on September 6, 2012 on the process of providing Notice of Medicare Non-Coverage letters. Administrator will audit weekly times four then monthly times three that residents ending Medicare services receive Notice of Medicare Non-Coverage letters.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of financial records and interview, the facility failed to provide timely Notice of Medicare Non-Coverage to one (#79) of five resident records reviewed. The findings included: Review of resident financial records revealed Resident #79 was discharged on April 1, 2012 due to resident reaching maximum potential with rehabilitation. Continued review revealed no documentation of a Notice of Medicare Non-Coverage was provided. Interview with the Business Office Manager on August 15, 2012 at 1:50 p.m. to 2:10 p.m., in the Business Office confirmed the facility failed to give at least two full days notice and the Notice of Medicare Non-Coverage was not completed.	F 156	**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Administrator or designee will report monthly times three to the PI committee the audit findings. (PI committee consists of minimally Administrator, DON, Social Services and Unit Managers/ADON's.) The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCGAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to protect the dignity of one resident (#104) during a random observation on the A Hall. The findings included: Resident #104 was admitted to the facility on February 5, 2012, with diagnoses including Alzheimer's Disease, Rehabilitation, and Muscle Weakness. Observation on August 15, 2012, at 9:48 a.m., revealed a group activity was being performed in the A Hall activity room with fifteen residents in attendance. Continued observation revealed two staff members were in the room; the Director of Activities was standing facing the group reading the headlines from the newspaper; and the other staff member (activity staff #2) was sitting in a chair near the doorway. The door into the room was open; and the wall separating the room from the hallway consisted of six full length glass panes allowing full visibility into the room. Continued observation revealed a nurse (Hospice RN #1) standing beside resident #104 performing a physical assessment. Observation revealed the	F 241	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #104 was returned to her room for privacy to be provided. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Hospice residents will be observed by the Unit Manager/ADON when hospice is providing care the week of September 10 to 14, 2012 to ensure residents are provided privacy and dignity.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 resident was positioned in a reclining Geri-chair and the abdomen was exposed between the top of the pants and the bottom of the shirt, approximately six inches. Continued observation revealed the Hospice RN #1 was using a stethoscope to assess the resident's anterior abdomen and chest. Continued observation revealed the hallway in front of the activity room was across from the nurse's station and was very busy with staff members and residents passing by. Observation and interview in the A hallway with the Unit Manager (UM) on August 15, 2012, at 9:58 a.m., revealed the nurse performing the assessment on resident #104 was not an employee of the facility, but was a contracted Hospice nurse. Continued interview revealed the UM was not familiar with the nurse and revealed the nurse was in orientation and "was supposed to be under the supervision of another (Hospice) nurse." Observation revealed the UM entered the activity room; spoke to the Hospice RN #1; and the UM and the Hospice RN #1 rolled the resident out of the activity room to the resident's room. Interview with the Hospice RN #1 and Hospice RN #2 on August 15, 2012, at 9:59 a.m., in the B wing hallway, confirmed the hospice RN #1 did perform a physical assessment on resident #104 with the abdomen exposed while in a group activity. Interview with the Activities staff member #2 outside the dining room on August 15, 2012, at 10:01 a.m., verified the Hospice nurse performed a physical assessment on resident #104 exposing	F 241	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** Immediately the Unit Manager/ADON Inserviced the Hospice Nurses on dignity and providing privacy. The Hospice Office Manager was contacted on August 15, 2012 by RN Consultant and notified of Hospice staff not providing resident privacy during an assessment. RN Consultant requested that the Hospice Provider provide an inservice to their staff members regarding providing privacy during assessments including taking residents to their room and not raising resident clothing in a public area. This inservice was conducted by the Hospice provider on August 15, 2012. Inservice was provided to the Activity Director and Activity Assistant on August 15, 2012 by RN Consultant on their role in maintaining privacy and dignity for residents. Unit Manager/ADON will weekly times four and then monthly times three audit Avalon hospice providers to assure that assessments are done in private and clothing is not rearranged in public view to expose resident's skin during care.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5 the abdomen during the group activity which did not maintain the dignity of the resident. Interview with the Director of Activities outside the dining room on August 15, 2012, at 10:02 a.m., confirmed the facility's failure to stop the nurse from conducting the physical assessment on the resident during a group activity resulted in failure to protect the resident's dignity.	F 241	**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Unit Manager/ADON or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to place a call light in reach of one resident (#24) of forty residents reviewed. The findings included: Resident #24 was admitted to the facility on February 13, 2009, with diagnoses including Cerebral Vascular Accident (Stroke), Muscle Weakness, Depressive Disorder, Joint Contracture Hand, Amputation Leg Unilateral, Dysthymic Disorder, Osteoporosis, Generalized Anxiety, Alzheimer's Disease, and Senile Dementia.	F 246	F246 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pillow was removed from between the resident and the left side rail of resident # 24 on August 14, 2012 by the SDC. Call light was moved to the right side of the bed on August 14, 2012 by the SDC and daughter was contacted regarding appropriate placement of resident's call light i.e. using call light clip versus tying call light with a glove. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 6 Medical record review of the Quarterly Minimum Data Set dated July 8, 2012, revealed the resident scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) indicating no cognitive impairments, was on a pain regimen, and was receiving pain medications for occasional mild pain. Medical record review of the Care Plan dated January 19, 2012, and updated August 6, 2012, revealed, "...At risk for alteration in comfort/pain...administer medications as ordered...position for comfort to decrease pain...Impaired ability to communicate needs...Call light within reach in room..." Observation and interview with the resident on August 14, 2012, from 9:14 a.m. until 9:20 a.m., revealed the resident lying in bed, with the head of the bed elevated, both upper quarter side rails in the raised position; a pillow positioned between the resident and the left side rail; and the call light tied with a glove to the left side rail, behind the pillow. The call light was out of the resident's view and reach. Interview with the resident revealed the resident complained the right shoulder was "...hurting very bad..." Continued interview revealed the resident had not told the nurse and stated "...have not seen her today..." and could not call the nurse because the resident was not able to reach the call light. Further observation and interview confirmed the resident's left hand was curled into a ball and the resident stated could not use the left hand. Observation and interview with Registered Nurse #3 on August 14, 2012, at 9:18 a.m., in the	F 246	Residents were checked for call lights within reach by Department Managers on August 14, 2012. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** Staff will be in serviced by the Staff Development Coordinator or designee on having call lights within reach for residents by September 12, 2012. Weekly audits times four then monthly times three by Department Managers will be conducted for call lights within reach. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Unit Manager/ADON or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RIN: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 7 resident's room, confirmed the resident could not reach the call light and when the resident was asked where to place the call light the resident stated "over here" holding up the right hand.	F 246		9/14/12
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	F278 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 16 MDS was corrected by MDS Coordinator on August 31, 2012. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** MDS Nurses will review residents who use meriwalkers to determine if they are a restraint by September 12, 2012. MDS coding will be compared to the findings of the review to ensure coding is correct. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** MDS nurses were inserviced by the DON on September 5, 2012 on coding of restraints. DON or designee will weekly times four and monthly times three audit MDS coding of meriwalkers for accurate coding.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINT: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 Based on medical record review, observation and interview the facility failed to accurately reflect the resident's status for one of five residents reviewed. The findings included: Resident #16 was admitted to the facility on August 4, 2008, with diagnoses including Vascular Dementia with Delusions, Delusional Disorder, Neurogenic Bladder, Depressive Disorder, Dysphagia, Hypertension, Anemia, and Senile Psychosis. Medical record review revealed physician orders listing the merry walker as a treatment; "merrywalker non-restraint able to release on command." Continued medical record review revealed the Physical Restraint Elimination Review dated November 13, 2011, revealed "patient ambulates using merry walker. (Resident) sits when tired and holds onto sides to assist with balance control when ambulating." Further medical record review revealed the Physical Restraint Elimination Assessment dated May 18, 2012, revealed "this resident has poor safety awareness secondary to Dementia. Resident is able to get into and out of the merrywalker without assistance, so the merry walker does not restrain (resident). " Observation of the resident on August 15, 2012, at 10:00 a.m., revealed the resident ambulating in and out of the bathroom with merrywalker parked outside of the bathroom. Interview with Licensed Practical Nurse (LPN) #2 on August 15, 2012 at 11:00 a.m., in the hallway	F 278	**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The DON or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9 confirmed the merrywalker was used for balance and was not a restraint. Record review of the annual Minimum Data Set dated June 4, 2012, listed the merrywalker as a restraint in section P (Restraints). Interview with the MDS Coordinator on August 15, 2012, at 2:00 p.m., in the MDS office, confirmed the facility failed to ensure the accuracy of the MDS assessments for the use of the merrywalker.	F 278		9/14/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 180 wound vac was added to the C.N.A. Communication Sheet on August 17, 2012 by the wound care nurse. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** C.N.A. Communication sheets for residents with wound vacs will be audited by the Wound Care Nurse to ensure that residents with wound vacs information is included on the Communication Sheet by September 12, 2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 by: Based on medical record review and interview, the facility failed to revise the Nurse Aide communication sheet to reflect the use and care of a wound vac for one resident (#180) of two of twenty-three residents reviewed. The findings included: Resident #180 was admitted to the facility on August 3, 2012, with diagnoses including Osteoarthritis, s/p (status post) Right Hip Replacement, Hypertension, Asthma, Anxiety, Schizophrenia, and Diabetes Mellitus Type 2. Medical record review of a physicians order dated August 3, 2012, revealed..."wound vac at 125 mmhg (millimeters of mercury)" Medical record review of the care plan dated August 3, 2012, revealed "...wound vac to right hip will remain patent...assess for s/o (signs of) infection, assess for comfort...change wound vac canister three times a week...change dressing to right hip as directed three times a week..." Medical record review of the CNA (Certified Nurse Assistant) Nurse Aide Communication Sheet, no date, revealed "...skin care-routine...notify your Charge Nurse of any changes in patient's skin condition...special (entries to include special skin concerns was left blank)..." Interview with CNA #1, on August 16, 2012, at 2:00 p.m., in the B Wing hallway, revealed the CNA was not familiar with the resident's plan of care and the wound vac. Continued interview	F 280	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Nurse will inservice nursing staff by September 12, 2012 on updating C.N.A. Communication Sheets with wound vac information. The Wound Care Nurse or designee will weekly times four and then monthly times three audit residents with wound vacs C.N.A. Communication Sheets to ensure wound vac is included on the sheet. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Wound Care Nurse or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 revealed "...we can look at the plan of care and see what needs to be done for the resident..." Review of the residents Nurse Aide Communication sheet with the CNA, revealed the communication sheet did not address the wound vac on the skin care portion of the communication sheet. Further interview with the CNA revealed "...this is where I would look to see what needs to be done for the resident and the wound vac is not written on the communication sheet..." Interview with the Admission Nurse, on August 16, 2012, at 2:30 p.m. in the B Wing Nurses Station, confirmed the Nurse Aide Communication sheet failed to address the wound vac and the wound vac should be documented on the communication sheet when the care plan was initiated and updated with any changes. Interview with the Director of Nursing (DON), on August 16, 2012, at 3:00 p.m., in the B Wing Nurses Station, confirmed the Nurse Aide Communication Sheet failed to address the residents wound vac and was not updated.	F 280		9/14/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an interim plan of care with measurable objectives and timetables to address the risk for complication associated	F 281	F281 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 127 no longer resides at the facility. Resident # 183 no longer resides at the facility. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Residents receiving anticoagulant therapy will have their interim care plan audited by MDS nurses to ensure interim care plans are in place for anticoagulant therapy by September 12, 2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 with anticoagulant therapy for two residents (#127, #183) of twenty-three residents reviewed. The findings included: Resident #183 was admitted to the facility on August 7, 2012, with diagnoses including Myocardial Infarction, Acute Altered Mental Status Change, Atrial Fibrillation with Rapid Ventricular Response, Type II Diabetes Mellitus, Thrombocyctopenia, and Acute Kidney Injury. Medical record review of a physician's order dated August 7, 2012, revealed "...Warfarin 2.5 mg (milligrams) P.O. (by mouth) once everyday at bed time..." Medical record review of the Interim Plan of Care (Developed on Admission) dated August 7, 2012, revealed no comprehensive plan of care with measurable objectives and timetables to address the risk for complication from anticoagulant therapy was developed on admission. Interview with the Director of Nursing on August 15, 2012, at 5 p.m., in the conference room, confirmed the facility failed to develop a plan of care on admission to address the risk for complication from anticoagulant therapy. The Director of Nursing stated, "It should have been there." Resident #127 was admitted to the facility on July 2, 2012, with diagnoses including Parkinson's Disease with Associated Dementia, Type 2 Diabetes Mellitus, Coronary Artery Disease, elevated Troponin, Right Lower Extremity Deep Venous Thrombosis, and Chronic Left Bundle	F 281	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The DON will inservice the admission nurse and the weekend supervisor on care planning anticoagulant therapy on admission /readmission on the interim care plan by September 12, 2012. The Staff Development Nurse will inservice nursing staff on care planning anticoagulant therapy on admission/ readmission on the interim care plan by September 12, 2012. Daily Monday through Friday interim care plans will be reviewed by the intradisciplinary team for new admissions/readmissions to ensure anticoagulant therapy is care planned. The MDS Nurse or designee will audit weekly times four and then monthly times three new admits/readmits care plans to ensure that anticoagulant therapy is included on the interim care plan. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The MDS Nurse or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RIN: 6/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 Branch Block. Medical record review of a physician's order dated July 2, 2012, revealed "...Warfarin 5 mg P.O. once a day..." Medical record review of the Interim Plan of Care (Developed on Admission) dated July 2, 2012, revealed no comprehensive plan of care with measurable objectives and timetables to address the risk for complication from anticoagulant therapy was developed on admission. Interview with the Director of Nursing on August 16, 2012, at 10:45 a.m., in the Director of Nursing's office, confirmed the facility failed to develop a plan of care on admission to address the risk for complication from anticoagulant therapy.	F 281		9/14/12
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain psychosocial services to address behaviors and medication management for one resident (#135) of ten residents reviewed for unnecessary medications. The findings included:	F 319	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 135 no longer resides at the facility. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 14 Resident #135 was admitted to the facility on July 13, 2012, with diagnoses including Rehabilitation, Dehydration, Failure To Thrive, and Anxiety State. Medical record review of the Admission Minimum Data Set dated July 20, 2012, revealed the resident scored 6 out of 15 on the BIMS (Brief Interview for Mental Status) indicating severe cognitive impairment, had a diagnosis of Depression, and received antianxiety and antidepressant medications for seven of the last seven days. Medical record review of a Nursing Evaluation Tool for a Behavior Change dated July 23, 2012, revealed, "Resident cursing staff and refusing (after) several attempts by different staff members. Resident yelling out/crying. Resident continues cursing and yelling out (after) reapproach by staff. Spoke (with) (family member) regarding behavior towards staff, aware of order for psych (psychiatric) consult...N.O. (New Order) psych consult to adjust meds (medications)..." Medical record review of a physician's order dated July 23, 2012, at 6:45 a.m., revealed, "psych consult to adjust meds." Medical record review of the Social Service Progress Notes revealed the following notes: "7/26/12...Pt (patient) also has anxiety and failure to thrive. Will consult psych for mood and med management...8/2/12 Care Plan mtg (meeting): (family member) attended care plan to discuss res. (resident) therapy, dietary needs, increasing	F 319	Social Services will audit charts of current in house residents for orders for psych referrals since July 2012 to ensure they have been completed by September 12, 2012. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Nurse will inservice nursing staff and Social Services by September 12, 2012 on psych referral process. Daily Monday through Friday orders will be reviewed by the intradisciplinary team for new psych orders. Social Services will verify new psych orders are received by the Psych consultant. Social Services will audit weekly times four and then monthly times three to ensure residents with new psych referrals are carried through and seen by psych. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Social Services Director or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 15 confusion and d/c (discharge) plans...expressed concern over res. mental health; psych referral requested and social services agreed..." Medical record review revealed no documentation a psychiatric consult had been obtained and no changes in medications based on a psychiatric evaluation. Interview with the Social Worker on August 16, 2012, at 3:40 p.m., in the conference room, confirmed the psychiatric consultation had not been obtained as ordered and requested by the family member.	F 319		9/14/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide supervision during a meal for one resident (#135) of three residents reviewed. The findings included: Resident #135 was admitted to the facility on July 13, 2012, with diagnoses including Rehabilitation, Pneumonia, Anemia, Dehydration, Diabetes	F 323	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 135 no longer resides at the facility. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Rehab Services Manager and or Unit Manager/ADON will audit in house residents that have had speech orders related to diet consistency changes requiring supervision since April 2012 to ensure orders are correct and are being followed by September 12, 2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 Mellitus II, Failure to Thrive, Anxiety State, and Vitamin Deficiency. Medical record review of the Admission Minimum Data Set dated July 20, 2012, revealed the resident scored 6 out of 15 on the BIMS (Brief Interview for Mental Status) indicating severe cognitive impairment, and required extensive assistance of one staff member for eating. Medical record review of a Communication Form signed by the Speech Therapist and dated August 15, 2012, revealed, "...Send To...Dining Services Nursing Services...Change food to mech (mechanical) soft...Pt (patient) needs supervision (with) all meals...needs reminders to alternate bites & (and) sips (1 bite & then 1 sip)..." Medical record review of a physician's order dated August 15, 2012, at 10:23 a.m., revealed, "ST (Speech Therapy) order - D/C (discontinue) puree order. Start pt on mech soft consistency, pt needs supervision (with) all meals..." Medical record review of the Nutritional Progress Notes dated August 15, 2012, revealed, "Diet Clarification. Resident's current diet is Puree with nectar thick liquids, diet has changed to mechanical soft with nectar thick liquids and resident needs supervision (with) all meals, for reminders to alternate bites & sips per speech therapy. Dietary will assign resident to dependent dining in room for assistance with meals." Observation on August 15, 2012, from 5:45 p.m., until 6:20 p.m., revealed the resident received the evening meal tray, which was set up for the resident, and the resident was left in the room to	F 323	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Coordinator will inservice therapy and nursing staff by September 12, 2012 on process for diet consistency changes requiring supervision. Daily Monday through Friday orders will be reviewed by the intradisciplinary team for diet consistency requiring supervision order changes. Unit Mangers will verify new diet consistency orders requiring supervision have been carried out. Unit Manager/ADON will audit weekly times four and then monthly times three to ensure residents with diet consistency order changes requiring supervision are being followed. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Unit Manager/ADON or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 feed self. Continued observations revealed no staff were present in the room between 5:45 and 6:20 p.m., and no staff entered the room to check the resident or assist the resident. Observations of the resident at 6:50 p.m., and 6:10 p.m., revealed the resident was self-feeding and the meal tray consisted of meatloaf, mashed potatoes, a peach dessert, ice cream, and a bread which the resident was gripping in the left hand. Interviews with Certified Nurse Technician (CNT) #1 on August 15, 2012, at 6:35 p.m., on the B Wing hallway, on August 16, 2012, at 10:00 a.m., in the conference room, and at 10:25 a.m., in another resident room on B Wing, confirmed the resident was served a mechanical soft evening meal tray, the tray was set-up for the resident, and the resident was left to self feed without assistance. Further interviews confirmed the resident usually feeds self and only needs set-up assistance with meal trays. Further interviews confirmed the evening meal was the first time the resident had received the mechanical soft meal and the resident had been receiving a pureed diet. Further interviews confirmed the CNT was unaware the resident was to be supervised during meals or the order for reminding one bite, one sip during meals. Interview with the Dietary Manager (DM) on August 16, 2012, at 10:15 a.m., in the conference room, confirmed the resident had been on a pureed diet based on speech therapy recommendations for risk of aspiration. Further interview confirmed on August 15, 2012, speech therapy upgraded the diet to a mechanical soft with nectar thick liquids and supervision with all	F 323		9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 meals. Continued interview confirmed the resident needed to be supervised to remind the resident to take one sip with each bite. Continued interview confirmed the DM had assigned the resident as a "Dependent Diner" indicated by a "D" on the dining cards to alert staff someone needs to stay with the resident during the entire meal and monitor for "whatever is needed." Interview and observation with the DM confirmed the resident's dietary card was imprinted with a "D" in the left hand corner and the resident was receiving a mechanical soft diet with nectar thick liquids. Interviews with the Speech Therapist on August 16, 2012, at 10:15 a.m., and 2:00 p.m., in the conference room, confirmed the resident had been placed on a pureed diet with nectar thick liquids due to coughing and trouble chewing in the past. Further interviews confirmed the resident had improved and the speech therapist changed the diet to mechanical soft with nectar thick liquids with supervision on August 15, 2012. Further interviews confirmed, "I recommended (resident) would need assistance...recommended supervision mostly for strategies with mechanical soft so (resident) would be reminded to take a bite then take a drink...concerned that (resident) was not clearing food out of (resident) mouth because if it is piling up and no one is watching (resident) could choke..." Further interviews confirmed it was not safe for the resident to eat without supervision and cueing to take a sip after each bite.	F 323	F328 **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 187's PICC Line was discontinued on August 29, 2012. LPN #3 was inserviced on checking for inflammation, infiltration and patency at the insertion site by the DON on September 4, 2012. **2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Residents with PICC lines had PICC lines assessed by ADON or Staff Development Coordinator for inflammation, infiltration and patency on August 31, 2012.	9/14/12
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 19 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there were no signs of inflammation or infiltration at the insertion site of PICC (Peripherally Inserted Central Catheter) line for one (#187) of two residents reviewed. The findings included: Resident #187 was admitted to the facility on July 23, 2012, with diagnoses including Aspiration Pneumonia, Hypertension, Benign Prostatic Hypertrophy, Malnutrition, and Stage 3 Decubitus. Observation of Licensed Practical Nurse (LPN) #3 on August 15, 2012, at 11:25 a.m., in the resident's room, revealed the resident lying in bed on right side with the right upper arm heavily wrapped in Kerlex covering the PICC line site. Continued observation of LPN #3 revealed LPN #3 cleaned, flushed the line, and administered Ampicillin intravenously (IV) to the PICC line. Further observation revealed LPN #3 did not visualize the site of the insertion to assess the condition of the skin around the line or patency of	F 328	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Coordinator will inservice nurses by September 12, 2012 on process for checking patency and inflammation and infiltration of skin around PICC line site. The Staff Development Coordinator or designee weekly times four and then monthly times three audit medication administration via PICC line during a nurse's medication administration to ensure PICC line sites are observed for inflammation, infiltration and patency at the site. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Staff Development Coordinator or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/15/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 20 the line. Interview with LPN #3 on August 15, 2012, at 11:45 a.m., outside the resident's room confirmed LPN#3 failed to assess the condition of the insertion site or patency of the PICC line before administering the medication and flushes.	F 328		9/14/12
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance checked refrigerators in medication rooms on A and B wing to ensure they are operating correctly on August 31, 2012. The DON provided new temperature logs for the medication room's refrigerators on August 14, 2012 that provides guidelines for refrigerator temperature normal ranges. New metal double lock narcotic cabinet was installed in the DON office on August 14, 2012 to secure narcotics. The Unit Manager/ADON audited the medication carts and medication rooms to verify that glucometer strips and Heparin bottles had been labeled and dated on August 31, 2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 21 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure proper and safe storage of drugs and biologicals in two of two medication rooms reviewed, and two of five medication carts reviewed. The findings included: Observation of the A wing medication room on August 13, 2012, at 4:45 p.m., with Licensed Practical Nurse (LPN) #4 present, revealed a small refrigerator for medication storage with the temperature log attached. Observation of the temperature log revealed temperatures for August 9th, 10th, and 12th, 2012, had not been recorded. Further observation revealed temperatures for July 15th, 16th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th, and 31st, 2012, had not been recorded. Further observation revealed the temperatures of the refrigerator exceeded 46 degrees on July 3rd, 5th, 6th, 9th, 10th, 12th, 14th, and 17th, 2012. Review of facility policy (Medication Administration - Storage of Medications), revealed the maximum temperture allowed is 46 degrees. Interview with LPN #4 on August 13, 2012, at	F 431	**2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** The Unit Manager audited the medication carts and medication rooms to verify that glucometer strips and Heparin bottles that had been opened were labeled and dated on August 31, 2012. The Unit Managers audited A and B Wing medication room's refrigerator temps on August 31, 2012 to ensure the temperatures are recorded and within range. Narcotics are now stored in a double locked metal cabinet attached to the wall. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Coordinator will inservice nurses on recording refrigerator temperatures and notifying maintenance if temperatures out of range, that glucometer strip bottles and Heparin bottles are dated when opened by September 12, 2012. The Unit Manager/ADON will audit weekly times four then monthly times three that refrigerator temperatures are recorded and within range, glucometer strip bottles and Heparin bottles are dated when opened.	9/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 22 5:00 p.m., in the A wing medication room, confirmed the refrigerator temperatures had exceeded 46 degrees, dates were not recorded, and had not been reported to the Director of Nursing (DON) or Pharmacist. Observation of the A wing short medication cart on August 13, 2012 at 5:00 p.m., on the A wing short hallway, with LPN #3 present, revealed three glucose test strips in a bottle which was opened and undated. Interview with LPN #3 on August 13, 2012, at 5:00 p.m., in the A wing hallway, confirmed the bottle of test strips was opened and undated. Observation of the B wing medication room on August 14, 2012, at 1:30 p.m., revealed a small refrigerator for medication storage with a temperature log attached. Further observation of the temperature log revealed no documentation of temperatures for July 7th, 8th, and 13th, 2012. Interview with LPN #1 in the B wing medication room on August 14, 2012, at 1:45 p.m., confirmed the temperature logs had missing documentation and the facility had failed to ensure the safe storage of medication. Observation of the B wing medication room on August 14, 2012, at 1:45 p.m., with LPN #1 present, revealed a wooden locked box for storage of narcotics with an accessible opening and attached to the wall of the medication room. The box had a eight by two inch opening where narcotics could be dropped into the box. The opening stood eighty inches above the floor.	F 431	**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Staff Development Coordinator or designee will report monthly times three to the PI committee the audit findings The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 23 Interview with LPN #1 on August 14, 2012, at 1:30 p.m., in the B wing medication room confirmed the facility had failed to provide a safe and secure storage of narcotics. Observation of the B wing short medication cart on August 13, 2012, at 5:00 p.m., in the hallway, with LPN #5 present, revealed a bottle of Heparin 5000 units per milliliter, opened and undated. Further observation of the medication cart revealed a bottle of eight opened and undated glucose test strips. Interview with LPN #5 at August 13, 2012, at 5:00 p.m., in the hallway, confirmed the Heparin and the bottle of glucose strips were opened and undated, and the facility had failed to ensure the proper and safe storage of medications and supplies.	F 431		9/14/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 165 no longer resides at the facility. Inservice was provided to housekeeper on not sweeping with resident food trays out by housekeeping supervisor on August 14, 2012. Inservice was provided to RN #1 by DON on September 5, 2012 on isolation policy and wearing gown while performing activities that may involve contact with the resident or potentially contaminated items in the residents environment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record and facility policy review, the facility failed to maintain infection control measures during random dining observation for one (#96) resident; and failed to follow isolation techiques during resident care for one resident (#165) during a random observation. The findings included: Observation in resident #96's room on August 14, 2012, at 8:06 a.m., revealed a housekeeper	F 441	**2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Staff caring for residents in isolation will be observed the week of September 10 to 14, 2012 for following infection control on wearing gowns during care by the Unit Manager/ADON. Housekeeping Supervisor will audit residents who eat breakfast in their rooms to ensure housekeeping is not sweeping while their trays are in their room the week of September 10 to 14, 2012. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 sweeping the floor near the resident's bed. Further observation revealed the resident's breakfast tray was exposed on the overbed table positioned over the bed and the resident was in the process of eating. Interview on August 14, 2012, at 8:08 a.m. in the room of resident #96, with Registered Nurse (RN) #2, feeding the resident during the observation, confirmed the housekeeper was sweeping the resident's room floor while the resident's tray was exposed and the resident was eating. Interview with the Housekeeping Director, on August 14, 2012, at 8:30 a.m. in the administrators' office, with the Administrator present, confirmed housekeeping staff were not to sweep when residents were eating.. Resident #165 was re-admitted to the facility on July 26, 2012, with diagnoses including Non-psychotic Brain Syndrome, Tracheostomy, Pressure Ulcers, Urinary Tract Infection, and MRSA (Methicillin-Resistant Staphylococcus Aureus). Medical record review of the Care Plan, dated July 25, 2012, revealed "...at risk for complications...contact isolation r/t (related to) MRSA..." Medical record review of a physicians order, dated August 2, 2012, revealed "...clarification order for Contact Precautions due to MRSA PEG-Tube..." Observation during medication pass, with the medication nurse, on August 16, 2012, at 8:27	F 441	The Housekeeping Supervisor will inservice the housekeeping staff by September 12, 2012 to not sweep floors while residents meal trays are in their rooms. The Staff Development Coordinator or designee will inservice nursing staff by September 12, 2012 on isolation procedures and wearing gowns while performing activities that may involve contact with the resident or potentially contaminated items in the residents environment. The Unit Manager/ADON or designee will audit weekly times four and monthly times three that isolation procedures are being followed. The Housekeeping Supervisor will audit weekly times four then monthly times three that housekeeping is not sweeping resident's rooms while resident's tray is in their room at breakfast. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Unit Manager/ADON and Housekeeping Supervisor or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26 a.m., in the resident's room, revealed a orange sign on the door "report to nurse's station" (indicating the resident was in isolation). Further observation revealed Registered Nurse (RN) #1 was not wearing a gown while assisting the resident with activities of daily living. Review of facility policy, Isolation-Categories of Transmission-Based Precautions, with a revision date of August 2007, revealed "contact precautions...Orange color coded sign is the color code for Contact Precautions...in addition to wearing a gown as outlines under Standard Precautions, wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment...remove the gown and perform hand hygiene before leaving the resident's environment..." Interview with RN #1, on August 16, 2012, at 8:40 a.m., in the B Wing Hallway, confirmed this nurse "...should have had a gown on while in the room with the resident..."	F 441		9/14/12
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure clean ice machines, for two (on A and B Hallways) of	F 465	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance cleaned the ice machines on A Wing and B wing on August 16, 2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 27 two ice machines. The findings included: Observation on August 16, 2012, at 10:00 a.m., in the A wing nourishment room, revealed an ice machine used for the residents, with a buildup of a brown colored debris to the inside top ledge. Further observation revealed the debris was easily removed when touched. Interview with Licensed Practical Nurse (LPN) #3, on August 16, 2012, at 10:00 a.m., in the nourishment room on the A Wing Hallway, confirmed the buildup of a brown colored debris to the inside top ledge on the ice machine and the debris was easily removed when touched. Observation on August 16, 2012, at 10:30 a.m., in the B Wing nourishment room, revealed an ice machine used for the residents, with a buildup of a brown colored debris to the inside top ledge. Further observation revealed the debris was easily removed when touched. Review of facility policy, Ice Machine and Ice Storage Chests, with a revision date of June 2005, revealed "...our facility has established procedures for cleaning and disinfecting ice machine...which adhere to the manufacturer's instructions..." Interview with the B Wing Unit Manager, on August 16, 2012, at 10:30 a.m., in the nourishment room on the B Wing Hallway, confirmed the buildup of a brown colored debris to the inside top ledge on the ice machine and the debris was easily removed when touched.	F 465	**2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;** Maintenance checked the ice machines in the facility on September 5, 2012 to ensure cleanliness was maintained. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and** Maintenance and or housekeeping will weekly check the ice machines on A and B Wing for cleanliness. The Administrator provided an inservice to Maintenance Director and Housekeeping Supervisor on September 5, 2012 on checking ice machines and cleaning of ice machines. The Maintenance Director will weekly times four and then monthly times three audit the ice machines in A and B Wing for cleanliness.	9/14/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The Maintenance Director/ Housekeeping Supervisor or designee will report monthly times three to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations.	9/14/12